		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012955

Facility Name: PROPHETS RIVERVIEW

Address: 310 MOSHER DRIVE (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 537-5175 **Fax #** (815) 537-2628

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners:

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: ALETA CARLSON **Telephone Number:** (605) 362-3843

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) ELOYE FARRELL
(Title) ASSISTANT SECRETARY

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)		7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)		18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS		25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,262	11,541	1,520	23,323	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,262	11,541	1,520	23,323	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.28%

D. How many bed-hold days during this year were paid by Public Aid?
25 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 9/20/1967

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,520

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	183,762	7,389	4,731	195,882		195,882		195,882			1
2	Food Purchase		121,825		121,825		121,825	(12,876)	108,949			2
3	Housekeeping	57,370	13,760		71,130		71,130		71,130			3
4	Laundry	50,161	12,006		62,167		62,167		62,167			4
5	Heat and Other Utilities			56,185	56,185		56,185	(4,781)	51,404			5
6	Maintenance	53,793	5,235	36,127	95,155		95,155	874	96,029			6
7	Other (specify):*			10,815	10,815		10,815	(422)	10,393			7
8	**TOTAL General Services**	345,086	160,215	107,858	613,159		613,159	(17,205)	595,954			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	936,300	115,346	9,109	1,060,755	(3,510)	1,057,245	(67,151)	990,094			10
10a	Therapy	7,073	794	51,399	59,266		59,266	(15,869)	43,397			10a
11	Activities	66,348	2,394	15,604	84,346		84,346	(2,100)	82,246			11
12	Social Services	29,514	24	957	30,495		30,495		30,495			12
13	Nurse Aide Training					7,172	7,172		7,172			13
14	Program Transportation			3,558	3,558	(657)	2,901		2,901			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,039,235	118,558	80,627	1,238,420	3,005	1,241,425	(85,120)	1,156,305			16
	C. General Administration											
17	Administrative	53,485		108,849	162,334		162,334	24,761	187,095			17
18	Directors Fees											18
19	Professional Services			1,500	1,500		1,500		1,500			19
20	Dues, Fees, Subscriptions & Promotions			9,965	9,965		9,965	(4,331)	5,634			20
21	Clerical & General Office Expenses	136,370	8,665	29,253	174,288		174,288	(7,075)	167,213			21
22	Employee Benefits & Payroll Taxes			335,346	335,346		335,346	(11,098)	324,248			22
23	Inservice Training & Education			9,294	9,294	(3,005)	6,289	(364)	5,925			23
24	Travel and Seminar			4,747	4,747		4,747		4,747			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,644	40,644		40,644	(6,233)	34,411			26
27	Other (specify):*											27
28	**TOTAL General Administration**	189,855	8,665	539,598	738,118	(3,005)	735,113	(4,340)	730,773			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,574,176	287,438	728,083	2,589,697		2,589,697	(106,665)	2,483,032			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROPHETS RIVERVIEW #0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			156,092	156,092		156,092		156,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4	4		4		4			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,443	6,443		6,443		6,443			35
36	Other (specify):*											36
37	**TOTAL Ownership**			162,539	162,539		162,539		162,539			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		41	2,721	2,762		2,762	(2,762)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*			4,791	4,791		4,791	(4,791)				43
44	**TOTAL Special Cost Centers**		41	45,837	45,878		45,878	(7,553)	38,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,574,176	287,479	936,459	2,798,114		2,798,114	(114,218)	2,683,896			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,172)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,331)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(108,145)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (121,648)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	7,430		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,430		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (114,218)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PROPHETS RIVERVIEW

ID# 0012955

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Uniform Inc	$ (1,244)	21	1
2	Administration	(83)	21	2
3	Wanderguard	(2,583)	21	3
4	Postage	(38)	21	4
5	Resident Supplies	(422)	7	5
6	Cable TV	(4,781)	5	6
7	Prescription Drugs	(43,399)	10	7
8	Beauty & Barber	(2,762)	40	8
9	Radio Service	(2,100)	11	9
10	Therapy Offset - TP, OT, ST	(15,869)	10A	10
11	Purch Svc - Laboratory	(2,053)	43	11
12	Purch Svc - Radiology	(1,586)	43	12
13	Contract Services - Radiology	(1,072)	43	13
14	Deferred Maint Exp - 2002	437	6	14
15	ProClaim Offset	(13,460)	10	15
16	Glucose Offset	(10,292)	10	16
17	C/Serv-Shared Emp	(3,123)	21	17
18	Staff Dev - Res Dev	(364)	23	18
19	Supplies - Res Dev	(1)	21	19
20	Telephone	(3)	21	20
21	Lab Fees	(80)	43	21
22	Deferred Maint Exp - 2003	437	6	22
23	Dietary Suppliment	(3,704)	2	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(108,145)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,876)	0	0	0	0	0	0	0	0	0	0	(12,876)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,781)	0	0	0	0	0	0	0	0	0	0	(4,781)	5
6	Maintenance	874	0	0	0	0	0	0	0	0	0	0	874	6
7	Other (specify):*	(422)	0	0	0	0	0	0	0	0	0	0	(422)	7
8	**TOTAL General Services**	(17,205)	0	0	0	0	0	0	0	0	0	0	(17,205)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(67,151)	0	0	0	0	0	0	0	0	0	0	(67,151)	10
10a	Therapy	(15,869)	0	0	0	0	0	0	0	0	0	0	(15,869)	10a
11	Activities	(2,100)	0	0	0	0	0	0	0	0	0	0	(2,100)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(85,120)	0	0	0	0	0	0	0	0	0	0	(85,120)	16
	C. General Administration													
17	Administrative	0	24,761	0	0	0	0	0	0	0	0	0	24,761	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,331)	0	0	0	0	0	0	0	0	0	0	(4,331)	20
21	Clerical & General Office Expenses	(7,075)	0	0	0	0	0	0	0	0	0	0	(7,075)	21
22	Employee Benefits & Payroll Taxes	0	(11,098)	0	0	0	0	0	0	0	0	0	(11,098)	22
23	Inservice Training & Education	(364)	0	0	0	0	0	0	0	0	0	0	(364)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(6,233)	0	0	0	0	0	0	0	0	0	(6,233)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(11,770)	7,430	0	0	0	0	0	0	0	0	0	(4,340)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,095)	7,430	0	0	0	0	0	0	0	0	0	(106,665)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(2,762)	0	0	0	0	0	0	0	0	0	0	(2,762)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,791)	0	0	0	0	0	0	0	0	0	0	(4,791)	43
44	**TOTAL Special Cost Centers**	(7,553)	0	0	0	0	0	0	0	0	0	0	(7,553)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(121,648)	7,430	0	0	0	0	0	0	0	0	0	(114,218)	45

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	ADMIN/ACCTG	$ 108,849	THE EV LUTHERAN GOOD SAMARITAN SOCIETY	100.00%	$ 133,610	$ 24,761	1
2	V								2
3	V	22	UNEMPLOYMENT	6,844			6,946	102	3
4	V								4
5	V	22	WORKERS COMP	51,281			41,886	(9,395)	5
6	V								6
7	V	26	INSURANCE	40,643			34,410	(6,233)	7
8	V								8
9	V	22	HEALTH INS	131,713			129,908	(1,805)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 339,330			$ 346,760	$ * 7,430	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1			NON APPLICABLE						$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The EV Lutheran Good Samaritan Sociey
Street Address: 4800 W 57th St PO Box 5038
City / State / Zip Code: Sioux Falls, SD 57117-5038
Phone Number: (605) 362-3100
Fax Number: (605) 362-3265

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1			NO ALLOCATION NECESSARY			$	$		$	1
2										2
3			SEE REPORT ON ALLOWABLE CENTRAL OFFICE EXPENSES FOR THE YEAR ENDED DECEMBER 31, 2002							3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NOT APPLICABLE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROPHETS RIVERVIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,259 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

APARTMETNS - 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1966	$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1967	1967	$ 347,119	$ 8,678	40	$ 8,678	$	$ 314,576	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Building		1973	1973	669	17	40	17		504	10
11			1974	1974	483	12	40	12		356	11
12			1975	1975	31,653	791	varies	791		22,947	12
13			1977	1977	4,675		20			4,676	13
14			1979	1979	7,265		20			7,265	14
15			1980	1980	2,114	9	varies	9		1,974	15
16			1981	1981	58,599	1,404	varies	1,404		33,658	16
17			1982	1982	8,456		varies			8,456	17
18			1983	1983	14,821	309	varies	309		14,821	18
19			1984	1984	8,772	439	varies	439		8,462	19
20			1985	1985	25,345	699	varies	699		24,508	20
21			1986	1986	7,033	15	varies	15		6,994	21
22			1987	1987	78,081	3,616	varies	3,616		63,965	22
23			1988	1988	48,071	1,127	varies	1,127		40,901	23
24			1989	1989	102,492	448	varies	448		102,205	24
25			1990	1990	922,006	41,759	varies	41,759		676,387	25
26			1991	1991	5,729	167	varies	167		5,268	26
27			1992	1992	24,956	535	varies	535		22,095	27
28			1993	1993	11,808	282	varies	282		9,780	28
29			1994	1994	45,574	1,000	varies	1,000		38,362	29
30			1995	1995	31,371	1,133	varies	1,133		24,857	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Floor Covering for Maint Room	1996	$ 605	$ 61	10	$ 61	$	$ 484	37
38	Bath Cabinets for Resident	1996	784	39	20	39		314	38
39	Ceiling Tile	1996	496	50	10	50		397	39
40	FRP Board and Supplies for 200	1996	205	14	15	14		108	40
41	Replace Water Lines from Boile	1996	6,000	240	25	240		1,860	41
42	Sanitizing Room/1/2 Down Payment	1996	5,497	550	10	550		4,352	42
43	Install Kemlite in 200 Wing	1996	453	23	20	23		178	43
44	Counter Top.Dining Room	1996	365	18	20	18		140	44
45	Lavatory Water Closet Tank	1996	445	22	20	22		171	45
46	York A/C Unit for 300 Wing	1996	7,100	473	15	473		3,550	46
47	Isolation Valves on Circulation	1996	1,300	130	10	130		964	47
48	Remove & Replace Counter	1996	600	40	15	40		297	48
49	AL & Partner Sys Configuration	1996	8,646		6			8,226	49
50	Steel Fire Doors	1996	2,857	143	20	143		1,059	50
51	Air Compressor for Air Handler	1996	511		5			488	51
52	Install Windows & Screens	1996	420	28	15	28		205	52
53	Water System	1996	4,500	225	20	225		1,631	53
54	Six Birch Dorts	1997	590	39	15	39		269	54
55	Amplifier-Intercom	1997	618	62	10	62		417	55
56	12000 BTU's Goodman Air Conditioner	1997	378		5			378	56
57	Green Louvered Shutters	1997	475	47	10	47		317	57
58	Install New Booster Heater	1997	1,286	129	10	129		847	58
59	Replaced Motor Coupling	1997	1,559	156	10	156		1,026	59
60	Reconfigured Water Heat Loop	1997	1,800	180	10	180		1,185	60
61	18 Rooms/Closet Doors/Comple	1997	6,320	421	15	421		2,739	61
62	Outdoor Home Sign	1997	1,000	66	15	66		433	62
63	36" Door Frame Guards/Contact	1997	1,127	75	15	75		495	63
64	Outdoor Home Sign	1997	2,000	200	10	200		1,283	64
65	Remodel Bath/Clean & Soiled UT	1997	33,471	1,338	25	1,338		9,149	65
66	Plumbing-Remodel 100 Wing	1997	504	25	20	25		172	66
67	Cabinets	1998	858	57	15	57		329	67
68	Counter Tops	1998	2,326	155	15	155		891	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,882,188	$ 67,446		$ 67,446	$	$ 1,477,371	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,882,188	$ 67,446		$ 67,446	$	$ 1,477,371	1
2	Building Continued								2
3	Photo Electric Smoke Detector	1998	420	42	10	42		235	3
4	Lavatory Faucet With Pop Up	1998	362	18	20	18		103	4
5	Plastering Walls	1998	2,500	208	5	208		2,500	5
6	Labor Material for Wallpaper	1998	3,966	396	10	396		2,181	6
7	Wallpaper & Border-Dining Room	1998	1,529	153	5	153		1,529	7
8	Wallpaper & Border-Dining Room	1998	2,925	292	5	292		2,925	8
9	Material for Wall and Painting	1998	6,125	715	5	715		6,125	9
10	Toilet & Tank	1998	373	37	10	37		202	10
11	Dining Room and Doors Korogard	1998	5,925	395	15	395		2,139	11
12	Nurses Station	1998	6,401	427	5	427		2,240	12
13	Wallcovering	1998	5,209	781	5	781		5,209	13
14	Carpet 450 SQ Yards	1998	10,077	1,343	5	1,343		10,077	14
15	Material and Labor to Cable	1998	6,033	302	20	302		1,609	15
16	Staff Entrance Hall Flooring	1998	1,151	211	5	211		1,151	16
17	Plumbing Repair	1999	2,644	264	10	264		1,322	17
18	Carpet	1998	3,750	647	5	647		3,750	18
19	Door on 300 Wing	1999	600	40	15	40		200	19
20	Grease Trap	1999	626	63	10	63		313	20
21	Lavatory Faucets	1999	732	37	20	37		180	21
22	Entrance Door on 200 Wing	1999	600	40	15	40		190	22
23	Pulled Stool Flange	1999	443	44	10	44		210	23
24	Boiler	1999	694	69	10	69		326	24
25	Gutters Replacement	1999	8,260	826	10	826		3,786	25
26	Rebuilt Corner/Overh. Porch	1999	560	56	10	56		252	26
27	Faucets	1999	1,070	54	20	54		241	27
28	Toliet Tanks	1999	1,628	81	20	81		366	28
29	Water Heater	2000	4,981	498	10	498		1,951	29
30	Flooring	2000	1,338	268	5	268		915	30
31	AM Standard Faucets	2000	953	48	20	48		165	31
32	Generator Repair	2000	966	97	10	97		322	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,965,029	$ 75,898		$ 75,898	$	$ 1,530,085	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,965,029	$ 75,898		$ 75,898	$	$ 1,530,085	1
2	Building Continued								2
3	Vinyl Floor Finish-Resident Rm	2000	7,427	743	10	743		2,287	3
4	Vinyl Flooring	2001	477	48	10	48		143	4
5	Lockset	2001	1,314	88	15	88		263	5
6	Door Locks	2001	1,825	122	15	122		365	6
7	Toilet	2001	353	18	20	18		50	7
8	Fire Alarm Panel	2001	395	25	15	25		91	8
9	Carpet For Wing Halls	2001	13,485	2,697	5	2,697		7,642	9
10	Carpet for Chapel & Hallway	2001	5,820	1,164	5	1,164		3,201	10
11	Toilets	2001	353	18	20	18		50	11
12	Air conditioner	2001	708	142	5	142		378	12
13	Wall Unit, Panels, Priv Screen	2001	968	65	5	65		156	13
14	Ceiling for dining Room	2001	1,394	93	15	93		209	14
15	Ventilation	2001	143,372	9,558	15	9,558		19,116	15
16	Corner Guards-Resident room	2001	162	16	10	16		34	16
17	Doors-Resident Room	2001	1,770	118	15	118		246	17
18	Duct Work-Resident Room	2001	2,139	107	20	107		223	18
19	AC For Beauty Shop	2001	329	66	5	66		175	19
20	Interior Partitions-Resid RM	2001	844	56	15	56		117	20
21	Paint-Resident room Remodel	2001	181	36	5	36		76	21
22	Corner Guards-Resident room	2001	558	56	10	56		116	22
23	Wallpaper-Resident Room Remode	2001	6,694	1,339	5	1,339		2,789	23
24	Carpet	2002	1,107	221	5	221		387	24
25	Blinds-Remodel 8 Rms	2002	217	43	5	43		47	25
26	Building-Remodel 8 Rms	2002	924	37	25	37		40	26
27	Corner Guards-Remodel 8 Rms	2002	139	14	10	14		15	27
28	Drapes-Remodel 8 Rms	2002	14	3	5	3		3	28
29	Duct Work-Remodel 8 Rms	2002	1,115	56	20	56		60	29
30	Plumbing-Remodel 8 Rms	2002	354	24	15	24		26	30
31	Shades	2002	364	73	5	73		79	31
32	Garage/Storage building	2003	60,774	4,052	15	4,052		4,052	32
33	Cabinet, Window-Kitchen	2002	1,726	173	10	173		273	33
34	TOTAL (lines 1 thru 33)		$ 2,222,331	$ 97,169		$ 97,169	$	$ 1,572,794	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,222,331	$ 97,169		$ 97,169	$	$ 1,572,794	1
2	Buildings Continued								2
3	Water Softner	2002	6,291	629	10	629		629	3
4	Dietary Entrance Door	2003	1,960	22	15	22		22	4
5	Dining Room counter Top & Base	2003	509	34	15	34		34	5
6									6
7	Land Improvement								7
8	Cement	1991	461	31	15	31		384	8
9	sidewalks 1967	1967	1,223		15			1,223	9
10	Walks-Drives-Parking	1975	3,363		15			3,363	10
11	Blacktop Parking Lot	1978	2,250		15			2,250	11
12	Fence-Sears	1978	604		15			604	12
13	Parking Lot Paving	1979	2,940		15			2,940	13
14	Trees-Plants and Overall Lands	1981	2,147		10			2,147	14
15	Landscaping	1982	2,492		10			2,492	15
16	Trees	1983	850		10			850	16
17	landscaping	1983	400		10			400	17
18	Trees Shrubs	1990	560		10			560	18
19	Flowers/Topsoil/Rock For Lands	1990	858		10			858	19
20	Gate and Fence Construction	1991	726		10			707	20
21	New Outside Sign	1992	2,895	241	12	241		2,714	21
22	sidewalks	1992	1,200	80	15	80		920	22
23	Landscaping Around Sign	1992	536		10			536	23
24	Landscaping	1992	2,446		10			2,446	24
25	Concrete and Labor	1991	1,381	92	15	92		1,159	25
26	Field Survey & Peat Prep	1991	1,400		10			1,374	26
27	Blacktop Parking Lot	1993	428	21	10	21		428	27
28	Fence-Sears	1994	1,049	70	15	70		676	28
29	Landscaping For Front	1995	4,152	415	10	415		3,529	29
30	1 Coat of Sealer To Parking Lot	1995	1,500		5			1,500	30
31	Gazebo & Preparation	1996	3,234	162	20	162		1,240	31
32	Remove Existing Payment	1997	7,843	392	20	392		2,516	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,278,029	$ 99,358		$ 99,358	$	$ 1,611,295	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,278,029	$ 99,358		$ 99,358	$	$ 1,611,295	1
2	Land Improvement Continued								2
3	Seal Coat Front Parking Lot	1997	2,500	250	10	250		1,604	3
4	Mulch Edging Fabric Weed	1998	582	49	5	49		582	4
5	Edging Pipedrain Elbow	1998	1,062	106	10	106		593	5
6	Gutter Screen Retaining Wall	1998	902	90	10	90		489	6
7	Perennial/Planting/Landscap	1999	1,726	155	10	155		639	7
8	Landscaping	2000	1,094	109	10	109		374	8
9	Parking Lot Overlay/Seal	2001	22,000	1,100	20	1,100		2,567	9
10	Retaining Wall	2003	3,412	28	20	28		28	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,311,307	$ 101,245		$ 101,245	$	$ 1,618,171	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 441,245	$ 44,619	$ 44,619	$		$ 486,835	71
72	Current Year Purchases	54,968	4,172	4,172			4,172	72
73	Fully Depreciated Assets	264,143						73
74								74
75	TOTALS	$ 760,356	$ 48,791	$ 48,791	$		$ 491,007	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Van	1992	$ 35,985	$	$	$	4	$ 35,985	76
77	Resident Care	1988 Cadillac Brougham	2000	3,510	878	878		4	2,925	77
78										78
79										79
80	TOTALS			$ 39,495	$ 878	$ 878	$		$ 38,910	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,126,158	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 150,914	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 150,914	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,148,088	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartmetns Unit 40	$	$	$	86
87	Building	65,102	2,465	46,257	87
88	FFE	8,528	188	7,760	88
89					89
90					90
91	TOTALS	$ 73,630	$ 2,653	$ 54,017	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 8,558	92
93			93
94			94
95		$ 8,558	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 6,443 Description: Computer equip lease, air fluid thpy bed, miscellaneous
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 92

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 41

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 2,555	$	$ 2,555
2	Books and Supplies		40		40
3	Classroom Wages (a)		2,437		2,437
4	Clinical Wages (b)		1,073		1,073
5	In-House Trainer Wages (c)				
6	Transportation		657		657
7	Contractual Payments				
8	Nurse Aide Competency Tests		410		410
9	TOTALS	$	$ 7,172	$	$ 7,172
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,172			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	425	$ 21,666	$	425	$ 21,666	1
2	Licensed Speech and Language Development Therapist		hrs		89	5,057		89	5,057	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		487	24,677		487	24,677	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	1,001	$ 51,400	$	1,001	$ 51,400	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,055	$	1
2	Cash-Patient Deposits	6,463		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	358,320		3
4	Supply Inventory (priced at)	17,882		4
5	Short-Term Investments	1,121,369		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,990		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,516,079	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	2,296,192		14
15	Leasehold Improvements, at Historical Cost	80,215		15
16	Equipment, at Historical Cost	808,379		16
17	Accumulated Depreciation (book methods)	(2,202,104)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	82,857		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Asset Manag, CIP	12,016		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,092,555	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,608,634	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 31,019	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	176,032		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,657		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Group Ins-emp Portion/Misc W/H	(383)		36
37	Security Dep - Apts	1,370		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 339,695	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 339,695	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,268,939	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,608,634	$	48

***(See instructions.)**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,113,600	1
2	Restatements (describe):		2
3	Net Income Unit 40 - Apartments	25,133	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,138,733	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	146,173	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Dnr Rst Prop Gft-Cash/End-Gen	18,515	15
16	Other (describe) CO/Foundation Fund, Cash Asset, Intra	(34,490)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 130,198	17
	B. Transfers (Itemize):		
18	Rounding	8	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 8	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,268,939	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,853,431	1
2	Discounts and Allowances for all Levels	(558,125)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,295,306	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	586	5
6	Therapy	238,565	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 239,151	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	522	12
13	Barber and Beauty Care	2,674	13
14	Non-Patient Meals	12,875	14
15	Telephone, Television and Radio	3	15
16	Rental of Facility Space		16
17	Sale of Drugs	96,445	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,797	19
20	Radiology and X-Ray	1,959	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 137,275	23
	D. Non-Operating Revenue		
24	Contributions	35,443	24
25	Interest and Other Investment Income***	158,775	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 194,218	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Nsg & Medical Supplies**	48,684	28
28a	**Schedule Attchd**	29,653	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 78,337	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,944,287	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	613,159	31
32	Health Care	1,273,053	32
33	General Administration	703,485	33
	B. Capital Expense		
34	Ownership	162,539	34
	C. Ancillary Expense		
35	Special Cost Centers	45,878	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,798,114	40
41	**Income before Income Taxes (line 30 minus line 40)****	146,173	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 146,173	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,890	2,069	$ 44,393	$ 21.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,368	8,376	151,446	18.08	3
4	Licensed Practical Nurses	12,822	14,444	214,451	14.85	4
5	Nurse Aides & Orderlies	52,593	57,686	532,762	9.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	381	428	7,073	16.53	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,696	1,953	22,783	11.67	9
10	Activity Assistants	4,879	5,697	45,201	7.93	10
11	Social Service Workers	1,870	2,025	29,178	14.41	11
12	Dietician					12
13	Food Service Supervisor	1,786	2,053	24,838	12.10	13
14	Head Cook	6,103	6,716	69,943	10.41	14
15	Cook Helpers/Assistants	9,447	10,734	89,104	8.30	15
16	Dishwashers					16
17	Maintenance Workers	4,091	4,537	52,227	11.51	17
18	Housekeepers	5,988	6,660	57,424	8.62	18
19	Laundry	5,937	6,379	49,789	7.81	19
20	Administrator	1,880	2,136	53,140	24.88	20
21	Assistant Administrator					21
22	Other Administrative	4,144	4,492	61,260	13.64	22
23	Office Manager	1,885	2,127	25,624	12.05	23
24	Clerical	1,896	2,120	19,899	9.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,753	2,073	22,539	10.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,409	142,705	$ 1,573,074 *	$ 11.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	123	$ 4,064		35
36	Medical Director	24	3,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	2,100		39
40	Physical Therapy Consultant	487	24,677		40
41	Occupational Therapy Consultant	425	21,666		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	89	5,057		43
44	Activity Consultant	36	2,277		44
45	Social Service Consultant	12	957		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,280	$ 63,798		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeanete Soleta	Administrator	100	$ 53,140
Vacation Accrual			345
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,485

B. Administrative - Other

Description	Amount
	$
Admin/Acctg	108,849
TOTAL (agree to Schedule V, line 17, col. 3)	$ 108,849
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Evangelical Lutheran	MDCD Cost Report	$ 800
Evangelical Lutheran	MDCR Cost Report	700
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,500

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,887
Unemployment Compensation Insurance	6,951
FICA Taxes	116,410
Employee Health Insurance	129,908
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Taxable Gifts	521
Admin/Consultant Savings	2,004
Staff Pension	26,567
TOTAL (agree to Schedule V, line 22, col.8)	$ 324,248

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,784
Health Care Worker Background Check	
(Indicate # of checks performed)	
Public Relations	1,507
Dues Reimbursement	4,112
Publications	1,561
Less: Public Relations	(1,507)
Less: Publications Reimbursable	(6,895)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,562

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,802
In-State Travel	876
Seminar Expense	69
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,747

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting - 6 Restrooms	10/00	$ 1,913	5	$	$	$ 383	$ 383	$ 381	$ 287	$	$	$
2	Painting - Ceilings	2/01	51	5			10	10	10	10			
3	Painting	5/01	9	5			2	2	2	2			
4	Painting	6/01	8	5			2	2	2	1			
5	Painting	8/01	44	5			9	9	9	10			
6	Painting	8/01	31	5			6	6	6	8			
7	Painting	8/01	34	5			6	6	6	11			
8	Painting	9/01	48	5			9	9	9	16			
9	Painting	6/01	10	5			2	2	2	2			
10	Painting	9/01	17	5			4	4	4	3			
11	Painting	9/01	17	5			4	4	4	3			
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,182		$	$	$ 437	$ 437	$ 435	$ 353	$	$	$

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network $3631

(3) Did the nursing home make political contributions or payments to a politica action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 28,085 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 38,325
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? YES Indicate the amount. $ 9,172

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 35%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: HENRY SCHOLTEN & CO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? N/A

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.